CSHCS PLAN OF CARE

Genesee County Health Department

Children's Special Health Care Services (810) 257-3146
Family Support Network (800) 359-3722

Child/Beneficiary ID Number	County Code 25
Child/Beneficiary Name	Date of Birth
Date of Contact	

☐ In Person ☐ Telephone

☐ SSI ☐ Medicaid/MiChild ☐ Medicare ☐ Private Insurance

Diagnosis

Diagnosis

Primary Care Physician

Specialist

Specialist

Specialist

Specialist

Specialist

Specialist

Specialist

Hospital

Hospital

Other

Other

Pharmacy

Beneficiary Name _____

Beneficiary Recipient ID # _____

Clients Health

Equipment and Supplies					
	Apnea Monitor		Feeding Chair		Positioning Devices
	A/C		Gastrostomy Supplies		Prosthesis
	Air Mattress		Glucometer		Pulse Oximeter
	Bath Chair		Hearing Aid		Scale
	Body Temperature Device		Hospital Bed		Shoe Lifts
	BP Monitor Equipment		House Ramp		Stander
	Car Ramp		Incontinent Supplies		Stroller
	Car Seat/ Booster		IV Therapy		Suction Machine
	Cochlear Implant Device		Lifting Device		Toileting Device
	Commode		Nebulizer/MDI		TPN Supplies
	Communication Device		Orthodontia		Tracheostomy Supplies
	CPAP/BiPAP		Orthotics		Ventilator
	Diabetic Supplies		Ostomy Supplies		Walker
	Dialysis Supplies		Oxygen		Wheelchair
	Eyeglasses		Peak Flow Meter		Other

Functional Status: (Functional Independence Measure-FIM)
7= independent; 6 = indep w/assist device; 5 = indep w/supervision; 4 = needs minimal aid; 3 = moderate aid; 2 = maximum aid; 1= dependent

Mobility:	ADLs:	
AMB _____	UE Dress _____	LE Bath _____
W/C _____	LE Dress _____	Toileting _____
TES	UE Bath	Feeding

DME Providers

_____
_____
_____
_____
_____
_____
_____

Drug, Food, Other Allergies:

_____
_____
_____

Method of Eating:
☐ Oral ☐ GT/JT ☐ NG
Diet: _____
_____

Primary Language: _____

Non-Verbal	Deaf	Leg. Blind both eyes
Slowed Speech/Aphasia	Moderate Hearing Loss	Leg. Blind-One-eye
Delayed Language	Mild Hearing Loss	Impaired Vision

Family Violence	Safety	Immunization	Healthy Habits			
No	Hazard	Up-to-date	Healthy Diet?	No	Yes	
Yes	☐ None	☐ No				
Susp	☐ Yes	☐ Yes	Exercises:	No	Yes	NA
	_____	☐ Unsure				
	_____		Smokes/Chem Dependency?	No	Yes	NA
	_____	☐ Verified				
	_____	☐ By history	Safer Sex Practices?	No	Yes	NA
	_____					
	_____		Lead	No	Yes	NA
	_____					

School/Program:

_____
_____
_____
_____

Therapies:

_____
_____
_____

Beneficiary Name _____

Beneficiary Recipient ID # _____

Medical	Medications
	Surgeries

Strengths:

_____
_____
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Concerns:

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Family Health Education Addressed (mark with X)

	Car Seats, Boosters		Family Violence		Prenatal Care
	Child Proofing		First Aid/ CPR Training		Public Health Services
	Clothing, Household Needs		Food Resources		Respite
	Comm. Dis/ Safe Practices		Health Care Clinics		Rights & Responsibilities
	CSHCS Program Basics		Healthy Diet		Safety-Home, Care, Recreation
	Day Care Services		Housing/Shelters		School Services
	Dental Care		Lead Testing		Sibling Support
	Diagnostics		Legal Aid		Safe Sleep
	Disease Process		Mental Health Service		Smoking Cessation
	Drugs/Alcohol use		MI Child/Healthy Kids		Special Recreation & Camps
	Environmental		Parenting Classes		Transition Services
	Exercise		Pest Control		Transportation
	Family Immunizations		Poison Control Center		Vocational Services
	Other		Other		Other

Beneficiary Name _____

Beneficiary Recipient ID # _____

Community Services and Resources

		Phone
Other Health Department Services		
Human Services (FIA)		
MSS/ISS		
Early On		
Does family have another case manager?		
Other Services		

Opportunity/ Concerns/ Issues Addressed	Goal of Intervention	Intervention and Person Performing Task	Outcome of completed intervention/ barriers

I participated and approve of this care plan and I give permission to share a copy of the Plan of Care with my primary care provider

Parent/ Legal Guardian/ Client Name (Print) _____

Parent/ Legal Guardian/ Client Signature _____ Date _____

Care Coordinator Name (Print) _____Phone _____

Care Coordinator Signature _____Date _____

Completed Copies sent to: ☐ Parents Date _____ ☐ Primary Care doctor Date _____